

**TRINITY UNITED METHODIST CHURCH 2010-2011
PARENTAL PERMISSION AND MEDICAL CONSENT FORM**

I/We the undersigned parents or guardians of _____ (name of minor) hereby grant permission for said minor to participate in the customary activities of Trinity United Methodist Church.

Student's full name _____
Last First Middle

Gender _____ Birth date _____ Age _____ Grade (as of Fall 2010) _____

Father's Full Name _____
Home Address _____
Home Phone _____ Business Phone _____
Cell Phone _____ Email _____

Mother's Full Name _____
Home Address _____
Home Phone _____ Business Phone _____
Cell Phone _____ Email _____

Other Relative or Responsible Person in case of Emergency
Name _____ Relation _____
Address _____ Phone _____

Please list any allergies the student may have including plants, animals, insects, medication, etc.

Does this student have any medical or health problems, and has this student had any chronic or recurring illness or illnesses, which would have an effect on the student's participation in activities? Yes _____ No _____
If yes, please describe _____

Last Tetanus Shot Date _____

Any current medications _____ If yes, please list (name and dosage)

Any other special restrictions or guidelines that adult leaders would need to know

**Please also complete the Insurance Information section and
include a notarized signature on the reverse side of this form.**

INSURANCE INFORMATION

*** PLEASE ALSO INCLUDE A PHOTOCOPY OF YOUR STUDENT'S INSURANCE CARD ***

Does this student have medical or hospitalization insurance covering them? _____

Insurance Company _____

Address _____ Phone _____

Policy # _____ Policy Holder _____

Physician's Name _____ Phone _____

Office Address _____

I/We hereby grant permission and authorize designated adult leaders of Trinity United Methodist Church to make emergency medical decisions on behalf of said minor in the event that I/We, the parents or legal guardians, cannot be contacted.

I/We also agree that the said insurance company will be used for such medical care and I/We are aware that I/We will be billed for any medical care not covered by the insurance.

Signature of Parent or Guardian _____

I have included a copy of my student's insurance card. _____ Yes _____ No

ACKNOWLEDGEMENT FOR PERSONS

STATE OF FLORIDA, COUNTY OF _____

Before me personally appeared _____ to me well known and known to me to be the person described in and who executed the foregoing instrument, and acknowledged to and before me that _____ executed said instrument for the purpose therein expressed.

WITNESS my hand and official seal, this _____ day of _____ A.D. _____

Notary Public
State of Florida at Large

My commission expires _____